



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DENISE BASKIND, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-12-1573-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: \$165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office had requested a Designated Doctor Exam to evaluate MMI/IR of the Lumbar Spine. The requestor was reimbursed the MMI portion and Impairment rating portion for 1 body area using DRE (Spine). Despite the diagnosis code, the evaluator performed an exam for MMI/Impairment rating of only the lumbar spine which concluded the injured employee with lumbar sacral strain, chronic, pre-existing degenerative changes (non-compensable), long standing chronic disc disease, this is pre-existing. The report further indicates that the impairment rating was assessed under lumbar spine DRE category II as 5% Whole person impairment which is consistent with the AMA Guides to evaluation of permanent impairment 4th edition, therefore the Office maintains that correct reimbursement was made for the impairment rating portion of the exam pursuant to Rule §134.204(4)(C)(ii)(I)."

Response Submitted by: State Office of Risk Management, P.O. BOX 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2011	99456-W5-WP and 99080-73	\$165.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated November 11, 2011
 - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.Explanation of benefits dated November 17, 2011
 - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
 - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed the amount of \$650.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and one body area/unit was billed in box 24G on the CMS-1500. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. According to 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category II method on the lumbar (spinal region) is \$150.00. The combined MAR for the MMI/IR exam is \$500.00. The requestor also billed \$15.00 for CPT code 99080-73. 28 Texas Administrative Code §134.204 states in part (k) that reimbursement "shall include Division-required reports." Therefore, no separate reimbursement is recommended for this report charge.
2. The respondent has already reimbursed the amount of \$500.00 for the disputed CPT code 99456-W5-WP and none is due for 99080-73. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 06, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.